

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042944

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1386

FILED DEC 9 1963

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 920 Corby St.		d. STREET ADDRESS (If outside, give location) 920 Corby St.	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First LEOLA Middle NORINE Last FREEMAN			4. DATE OF DEATH Month Found Dec. Day 2 Year 1963		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-11-1901	9. AGE (last birthday) 62	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Joseph, Mo.	
				12. CITIZEN OF WHAT COUNTRY USA	

13a. FATHER'S NAME John P. Freeman		13b. MOTHER'S MAIDEN NAME Mary Jane Conniff		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Mrs Earle Sanders Address St. Joseph, Mo.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 5 1/2 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic heart disease	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	

21. I attended the deceased from 1952 to time of death and last saw her alive on Oct 63 Death occurred at not known m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE Clarence C. Sidenfaden (Degree or title)	22b. ADDRESS St. Joseph, Mo.	22c. DATE SIGNED 12-2-63
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec. 4, 1963	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
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24. FUNERAL DIRECTOR H. O. Sidenfaden & Son ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Dec. 3, 1963	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
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(Licensed Embalmer's Statement on Reverse Side)

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Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF C.C. DuMont, Mayor, Certification

USE BLACK INK
OR
TYPEWRITER RIBBON

Permit issued 12-3-63

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert H. Geph
Licensed Embalmer No. 3308

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.